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Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1832-P)

Dear Administrator Oz,

The American Academy of Audiology (the Academy) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM) regarding revisions to Medicare payment policies under the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2026. The Academy is the largest professional organization dedicated to audiologists, representing the profession through education, research, advocacy, and the advancement of quality hearing and balance care. Our members deliver essential diagnostic and rehabilitative services to Medicare beneficiaries, including some of the nation's most vulnerable populations.

The NPRM includes announcements and proposals for substantive policy changes, including some of deep concern to audiologists. Herein, we will provide comments on the following topics within the NPRM:

- **Medicare Conversion Factor**
- **Proposed Efficiency Adjustment**
- **Updates to Practice Expense Methodology**
- **Revisions to the Telehealth Services and Flexibilities**
- **Artificial Intelligence and Software as a Service (SaaS)**
- **Hearing Device Services Codes**

Medicare Conversion Factor

The Academy welcomes the proposed increase in the Medicare Physician Fee Schedule conversion factor (CF)—the first in five years. While this step is appreciated, we strongly urge CMS to pursue more meaningful and sustainable updates that reflect the real cost of delivering care. Clinicians continue to face rising practice expenses, which are projected to increase by 2.7% in 2026 under the Medicare Economic Index (MEI). The temporary +2.5% update mandated by H.R. 1 is insufficient to offset these rising costs or to ensure the long-term sustainability of audiology practices. We are also deeply concerned that the rule fails to incorporate a cost-of-living adjustment, as recommended by MedPAC, or any alternative mechanism to address ongoing inflationary pressures on clinical care.

Beginning in 2026, two separate CF updates will apply: +0.25% for most physicians and +0.75% for participants in Advanced Alternative Payment Models (APMs). Because no audiology-specific APMs currently exist, audiologists will be categorically excluded from receiving the higher update, perpetuating inequities across specialties. At the same time, the proposed -2.5% efficiency adjustment would negate any modest gains from the statutory update, further eroding reimbursement. Compounding these concerns, CMS's continued overestimation of G2211 utilization distorts budget neutrality calculations and places additional downward pressure on payment rates across the MPFS.

For these reasons, we strongly reiterate the need for CMS and Congress to advance a durable, long-term solution to the structural challenges facing the MPFS. Sustainable updates that accurately reflect practice costs are essential to maintain the financial viability of audiology practices and to protect Medicare beneficiaries' access to essential diagnostic and rehabilitative hearing and balance services. Without such reforms, practices will continue to face mounting financial instability, threatening both the provider workforce and patient access to timely, high-quality care.

Proposed Efficiency Adjustment

We strongly oppose CMS's proposed "efficiency adjustment," which would automatically reduce all work RVUs by 2.5 percent every three years. This proposal is arbitrary, lacks empirical justification, and directly undermines the integrity of the RUC process, which CMS has long recognized as the primary mechanism for ensuring accurate, evidence-based valuation of physician work. The RUC's methodology already incorporates relativity, intensity, and efficiency into its deliberations. It also conducts ongoing reviews of services—drawing on survey data, clinician experience, and specialty society input—to ensure valuations reflect real-world practice. By imposing a blanket adjustment outside of this established framework, CMS is effectively second-guessing a process specifically designed to achieve relativity, while doing so without evidence, transparency, or specialty-specific data.

Of particular concern to audiology is CMS's inappropriate application of the efficiency adjustment to time-based codes. Several audiology-specific CPT codes were included in CMS's calculations despite being explicitly time-based. Their inclusion reflects a flawed rationale for assuming additional efficiency gains and highlights fundamental flaws in the methodology. This concern is especially acute for audiology, where clinicians devote significant amounts of unreimbursed time engaging with patients but lack access to evaluation and management (E/M) codes to capture this work. The policy fails to distinguish between services already reviewed for efficiency through the RUC process and those that might legitimately warrant further examination.

At a minimum, CMS should remove audiology's time-based diagnostic codes from the efficiency adjustment (see table below) and clearly define the criteria and process by which codes are included or excluded. Transparency, consistency, and formal clinical input are essential to ensure efficiency adjustments are applied appropriately.

Time-Based Codes Subject to Efficiency Adjustment in Error

Time Based Code	Long Descriptor	CY2026 MPFS Proposed Rule wRVU (including -2.5% adjustment)
92620	Evaluation of central auditory function, with report; initial 60 minutes	1.46
92621	Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)	0.34
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	1.22
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)	0.32
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	1.72

The practical outcome of this policy will be systemic misvaluation of audiology services. Practices will face unsustainable financial strain as the work and intensity associated with audiology services are artificially suppressed. Ultimately, this threatens Medicare beneficiaries' access to essential diagnostic and rehabilitative hearing and balance care—services that are critical to communication, independence, and quality of life for some of the most vulnerable populations.

We further urge CMS to abandon its proposal to impose recurring efficiency adjustments every three years. Instituting across-the-board reductions without robust clinical review will perpetuate misvaluation, destabilize payment rates, and discourage innovation.

Given our significant concerns, we support the RUC's recommendation to reject the proposed efficiency adjustment. Instead of applying across-the-board reductions, we encourage CMS to continue pursuing a targeted, data-driven collaborative approach that emphasizes careful review of high-volume or potentially misvalued services through the well-established RUC and CMS processes. This approach helps safeguard accuracy and ensures that valuations reflect the actual clinical work and resource use associated with each service, while preserving the integrity and relativity of the process.

Clinician input into relativity is indispensable. The RUC process ensures that valuations are informed by practicing clinicians who best understand the time, complexity, and intensity of the services they provide. Overriding this process with arbitrary efficiency adjustments disregards the statutory framework established by Congress and undermines confidence in the Medicare Physician Fee Schedule as a fair, evidence-based payment system.

We recommend that CMS work collaboratively with the RUC and specialty societies to develop a transparent, clinician-led process for identifying genuine efficiencies, supported by robust clinical data and stakeholder input, rather than imposing recurring and negative blanket adjustments to payment policy.

Updates to Practice Expense Methodology

We appreciate the opportunity to comment on CMS's proposal to refine significantly the current practice expense (PE) methodology to better reflect trends in clinical practice settings. While we support CMS's commitment to improving accuracy in practice expense calculations, we remain concerned about the proposed changes—particularly given CMS's own acknowledgment in the Proposed Rule of the need to "work with the AMA to understand if and how such data should be used in PFS rate setting in future rulemaking."

We also appreciate CMS providing detailed information on the proposed use of updated Physician Practice Information (PPI) and Clinical Practice Information (CPI) data in determining the Medicare Economic Index (MEI) weights for physician work, practice expense, and professional liability insurance. However, the 60-day comment period is insufficient for stakeholders to thoroughly review the methodology, assess specialty-specific implications, and develop the analyses necessary for meaningful feedback. This concern is compounded by CMS presenting several alternative approaches for applying the new data, each with potentially significant consequences across specialties.

CMS declined to adopt the 2024 AMA PPI and CPI survey data for CY 2026 rate-setting due to representativeness concerns, yet simultaneously proposes a sweeping, untested methodology change. This inconsistency underscores why it is premature to move forward with major revisions to the PE methodology without validated integration of the new datasets. Proceeding under the current proposal risks distorting practice expense valuation, destabilizing payment accuracy, and compromising patient access. We therefore urge CMS to delay implementation of PE methodology changes until the 2024 PPI and CPI data are fully analyzed, incorporated into both PE methodology and MEI weights, and shared with stakeholders for meaningful review and input.

This caution is particularly critical for audiology, where small, office-based practices rely on costly, highly specialized diagnostic equipment and technology. A methodology that fails to fully capture these real-world expenses risks destabilizing independent audiology practices, limiting access for patients, and undermining sustainability in both rural and urban communities.

Finally, overlapping policy changes heighten the risk of disruption. CMS is simultaneously proposing an efficiency adjustment, broader site-of-service differentials, and a major redistribution of PE inputs. Each of these proposals individually has substantial implications for payment accuracy and practice stability; taken together, they magnify uncertainty and the likelihood of unintended consequences. This convergence of policies threatens to destabilize office-based audiology practices, restrict access—particularly in rural and underserved areas—and undermine long-term planning and investment in essential diagnostic technologies.

Given the magnitude of these proposed refinements, additional engagement is essential before such sweeping changes are implemented. We urge CMS to delay implementation of the new practice expense methodology as proposed. Instead, CMS should convene structured listening sessions with the AMA, specialty societies, and other stakeholders to (1) validate and incorporate the 2024 AMA PPI and CPI data, replacing the outdated 2007 data, and (2) ensure that the methodology is fully vetted, transparent, and reflective of real-world practice. Direct engagement will allow CMS to identify unintended consequences, incorporate specialty-specific insights, and ensure equitable and accurate application before moving forward.

Revisions to the Telehealth Services and Flexibilities

In the proposed rule, CMS outlines revisions to the five-step process for reviewing requests to the Medicare Telehealth Services List. The Academy supports CMS's proposal to streamline this process by focusing on whether a service can be effectively and safely delivered via telehealth technology. We also agree that physicians and other practitioners, with their knowledge of a patient's clinical needs and professional judgment, are best positioned to determine when a service is clinically appropriate for delivery through interactive telehealth.

The Academy further supports the removal of the "provisional" and "permanent" designations and the placement of all currently approved codes on the Medicare Telehealth Services List. We appreciate CMS's recognition of the value of telehealth in improving access to care—particularly for older adults, rural populations, and patients facing mobility or transportation barriers. We are especially grateful for CMS's decision to add auditory osseointegrated sound processor services (CPT codes 92622 and 92623) to the Medicare Telehealth Services List. This important step affirms the clinical validity of remote sound processor programming and verification and meaningfully expands access for Medicare beneficiaries.

At the same time, we remain concerned that audiology telehealth services more broadly continue to face limitations under current CMS policy. As technology advances, remote diagnostic and rehabilitative audiology services—including auditory rehabilitation and additional device programming—should be recognized as clinically appropriate and reimbursable under Medicare when furnished via telehealth. We are encouraged that CMS is proposing to continue expanding telehealth-eligible audiology services on a permanent basis and urge the agency to ensure that payment policies reflect the true clinical and operational costs of delivering these services.

Congressional flexibilities enacted during the COVID-19 pandemic facilitated widespread adoption of telehealth and have been extended multiple times. Absent further Congressional action, these flexibilities are set to expire on September 30, 2025. Additionally, the CY 2025 Medicare PFS Final Rule extended through December 31, 2025, the policy allowing physicians to provide direct supervision remotely. Together, these actions underscore bipartisan recognition of telehealth's essential role in sustaining access to care.

We support the changes proposed in the NPRM and strongly urge CMS to build on this progress by modernizing coverage for audiology telehealth services, ensuring equitable access for Medicare beneficiaries in both rural and urban communities, and supporting the long-term sustainability of practices that provide these essential services.

Artificial Intelligence and Software as a Service (SaaS)

CMS is seeking comment on how to integrate the costs of software-as-a-service (SaaS)—including Artificial Intelligence (AI) tools—into the rate-setting process for the Medicare Physician Fee Schedule (MPFS). The Academy appreciates CMS's recognition that current practice expense (PE) methodology does not adequately capture the costs associated with SaaS and AI-driven technologies, and we welcome the opportunity to provide input on the factors CMS should consider when establishing payment for these services.

We strongly support the establishment of a clear reimbursement pathway that ensures continued innovation in AI-enabled medical technology. For audiology in particular, AI-driven tools have the potential to transform hearing and balance care by enhancing diagnostic accuracy, supporting clinical decision-making, and improving

the precision of device programming and rehabilitation services. Medicare reimbursement must reflect both the clinician work and the practice expense associated with these technologies.

Importantly, funding for SaaS and AI should not be absorbed within the existing payment pool, which is already strained. Instead, CMS should establish a mechanism to separately identify and reimburse the costs of SaaS and AI technologies to ensure fair valuation and sustainable adoption. To support accurate rate-setting, CMS should collect data from a broad range of stakeholders—including manufacturers, practicing clinicians who purchase and use these tools, and other experts engaged in implementation and patient care.

By ensuring a forward-looking reimbursement structure, CMS can foster the integration of AI-enabled services into hearing and balance care, as well as broadly across healthcare, to improve access, accuracy, and quality of care for Medicare beneficiaries.

Hearing Device Services Codes

The NPRM announces a set of 12 new CPT codes, effective January 1, 2026, that describe more accurately the range and intensity of services provided by audiologists. These codes reflect a major effort to modernize audiologic coding to report professional hearing device services, particularly to account for differences in patient complexity, age, and clinical need. The legacy codes have been in place since 1993 and do not reflect the evolution from analog to digital hearing aid technology and the scope of contemporary audiologic practice. The Academy and the American Speech-Language-Hearing Association (ASHA) jointly led a multi-year process that involved extensive collaboration among clinical experts, coding professionals, and practice leaders, as well as engaged other interested stakeholders from the audiology and physician communities to provide input and feedback regarding the development of the code structure. We look forward to the implementation of the new code set in 2026 and do not request any specific action by CMS.

Conclusion

The American Academy of Audiology urges CMS to reconsider the proposed efficiency adjustment, delay implementation of practice expense methodology changes until they are further refined, expand recognition of audiology telehealth services, and work with Congress to stabilize the conversion factor. These actions are essential to ensure accurate valuation of audiology services, preserve the integrity of the Medicare Physician Fee Schedule, and support the long-term financial viability of practices that provide critical diagnostic and rehabilitative hearing and balance care. Just as importantly, they will help ensure that Medicare beneficiaries continue to receive timely, high-quality hearing and balance services that are vital to communication, independence, and quality of life.

We appreciate your consideration of these comments and stand ready to collaborate with CMS on solutions that strengthen payment policy, reflect the realities of clinical practice, and promote sustainability and innovation within the Medicare program.

Sincerely,

Patricia Gaffney, AuD, MPH
President